

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR BENEFICIARIES WITH
INSTITUTIONAL STATUS**

**GROUP HEALTH PLAN
EARTH CITY, MISSOURI**



JANET REHNQUIST
INSPECTOR GENERAL

JANUARY 2002
A-05-01-00070



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

January 25, 2002

Common Identification Number: A-05-0 1-00070

Davina C. Lane, President & CEO
Group Health Plan
111 Corporate Office Drive, Suite 400
Earth City, Missouri 63045

Dear Ms. Lane:

This final report provides the results of our audit entitled, "Review of Medicare Payments for Beneficiaries with Institutional Status." Our objective was to determine if capitation payments to Group Health Plan (Contract H2663) were appropriate for beneficiaries reported as institutionalized.

We determined that Group Health Plan received Medicare overpayments totaling \$11,089 for 13 beneficiaries incorrectly classified as institutionalized. The 13 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries, reported as institutionalized during the period January 1, 1998 through December 31, 1999. Based on our sample results, we estimate that Group Health received Medicare overpayments of \$98,689 for beneficiaries incorrectly reported as institutionalized. The causes of the overpayments include difficulties with Group Health's verification and reporting process, incorrect information provided by nursing facilities, and an incorrect interpretation of institutional payment regulations.

INTRODUCTION

BACKGROUND

The Balanced Budget Act of 1997, Public Law 105-33, added sections 1851 through 1859 to the Social Security Act and established the Medicare + Choice (M+C) Program. Its primary goal was to provide a wider range of health plan choices to Medicare beneficiaries. The options available to beneficiaries under the program include coordinated care plans, medical savings account plans, and private fee-for-service plans. Coordinated care plans have a network of providers under contract to deliver a health benefit package, which has been approved by the Center for Medicare and Medicaid Services (CMS). Types of coordinated care organizations include health maintenance organizations, provider sponsored organizations, and preferred provider organizations. Beneficiaries eligible to enroll in the new M+C Plans must be entitled to Part A and enrolled in Part B.

The CMS makes monthly advance payments to managed care organizations (MCOs) at the per capita rate set for each enrolled beneficiary. Medicare pays a higher monthly rate to MCOs for beneficiaries who are institutionalized. The MCOs receive the enhanced institutional rate for enrollees who are residents of Medicare or Medicaid certified institutions; such as skilled nursing facilities (Medicare), nursing facilities (Medicaid), intermediate care facilities for the mentally retarded, psychiatric hospitals or units, rehabilitation hospitals or units, long-term care

and swing-bed hospitals. Institutional status requirements contained in Operational Policy Letter #54 specify that the beneficiary must be a resident of a qualifying facility for a least 30 consecutive days immediately prior to the month for which an institution payment is being made.

The MCOs are required to submit to CMS, a monthly list of enrollees meeting institutional status requirements. The advance payments received by MCOs each month are subsequently adjusted by CMS to reflect the enhanced reimbursement for institutional status. For example, during 1999, MCOs in the St. Louis area received a monthly advance payment of \$578 for each 85 years old male beneficiary residing in a non-institutional setting. If the beneficiary were reported to CMS as institutionalized, the advance payment would have been adjusted to \$1,040.

SCOPE OF AUDIT

Our audit was performed in accordance with generally accepted government auditing standards. Our objective was to determine if capitation payments to Group Health Plan (Contract H2663) were appropriate for beneficiaries reported as institutionalized during the period January 1, 1998 through December 31, 1999. This review was performed as survey work prior to our national review of institutional status issues.

A simple random sample of 100 was selected from a universe of 890 Medicare beneficiaries that Group Health reported as institutionalized during the audit period. From Group Health, we obtained the names and addresses of the nursing facilities in which the beneficiaries in the sample resided. The facilities were contacted to verify that the beneficiaries were institutionalized for the months that Group Health reported to HCFA. Based on the residency information obtained from the nursing facilities, we identified Medicare beneficiaries who were incorrectly reported as institutionalized. The Medicare overpayment for each incorrectly reported beneficiary was calculated by subtracting the non-institutional payment that Group Health should have received from the institutional payment actually received.

Using the overpayments identified in our sample, we projected the probable value of Medicare overpayments in the universe of beneficiaries. Details of our statistical sample and projection are shown on Appendix A.

Our field work was performed during November and December 2000 in St. Louis, Missouri and in our field office in Columbus, Ohio.

RESULTS OF AUDIT

Group Health received Medicare overpayments of \$11,089 for 13 beneficiaries incorrectly classified as institutionalized. The 13 beneficiaries were part of a statistical sample of 100 Medicare beneficiaries, reported as institutionalized during the period January 1, 1998 through December 31, 1999. Based on our sample results, we estimate that Group Health received Medicare overpayments of \$98,689 for beneficiaries incorrectly classified as institutionalized. The causes of the overpayments include difficulties with Group Health's verification and reporting process, incorrect information provided by nursing facilities, and an incorrect interpretation of institutional payment regulations.

Group Health's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the MCO are adequate. The internal control procedures require that Group Health receive a fax each month from the nursing facilities, verifying each beneficiary's residency, prior to submitting the list of institutionalized members to HCFA. This verification system was not in place during our audit period. Difficulties in the application of Group Health's prior verification process resulted in seven beneficiaries in our sample being incorrectly reported as institutionalized. Three other beneficiaries were incorrectly reported to HCFA because nursing facilities provided incorrect information to MCO staff that called to verify residency.

We also questioned payments for three beneficiaries that were hospitalized during their initial 30 days of institutional residency and were claimed at the enhanced rate in the subsequent reporting month. The enhanced rate cannot be claimed until after a beneficiary completes 30 consecutive days of institutional residency. If the beneficiary has a hospital stay during the initial 30-day period, the count must begin again. When the 30-day period is completed, the enhanced rate is payable for subsequent months of institutional residency and hospital stays of 15 days or less do not void a beneficiary's institutional status.

RECOMMENDATIONS

We recommend that Group Health:

1. Refund the overpayments identified through our review totaling \$11,089.
2. Review the balance of the institutionalized beneficiary universe to identify and refund the additional overpayments. We estimate total overpayments to be \$98,689.

Since Group Health implemented new verification procedures for institutional residency after our audit period, we are making no internal control recommendations.

AUDITEE COMMENTS AND OIG RESPONSE

We questioned payments for three beneficiaries that were hospitalized during their initial 30 days of institutional residency. In their response to our draft report, Group Health officials state that they believe hospital stays during the first 30 days of institutional residency are allowable under the standards set forth by CMS in Operational Policy Letter #54 (OPL-54). As a result, Group Health officials believe that the questioned institutional payments for the three beneficiaries should be removed from our sample findings and from the statistical projection of total Medicare overpayments.

We disagree with this interpretation of the institutional status requirements. Operational Policy Letter (OPL) #54 states that:

...To be considered institutionalized, an enrolled member must have been a resident of one the following title XVIII (Medicare), or title XIX (Medicaid) certified institutions for at least 30 consecutive days immediately prior to the month for which payment is being made...A Medicare enrollee must have been a resident of the

above institutions for a minimum of 30 consecutive days which includes, as the 30th day, the last day of the month prior to the month for which the higher institutional payment is paid....

In addition, OPL #54 says that:

...CMS will continue to pay the institutionalized AAPCC payment rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave if a bed is being held and paid for on behalf of the member. Temporary interruptions (less than 15 days) for medical necessity will be counted toward the 30-day requirement....

If a beneficiary has not qualified for institutional status prior to a hospital stay, Medicare cannot continue to pay, because the institutional payments have not yet started. Beneficiaries must have an initial 30 days of institutional residency, prior to a hospital stay, for the temporary absence not to void institutional status.

Regional Office HMO/CMP Letter 93-12 issued in Region IX on December 14, 1993 offers additional support for our interpretation of reimbursement guidelines and illustrates long-standing reimbursement policy. The letter states:

...To be considered eligible for the institutionalized rate cell a Medicare beneficiary must have been a resident of a skilled nursing facility...for a minimum of 30 consecutive days immediately prior to the first day of the current month....

...Acute care hospitals are excluded from the definition of institutions for the purpose of determining institutional status....However, **once the member has met the institutional definition (emphasis added)**, the HMO may continue to categorize him/her as institutionalized if institutionalization is interrupted by an acute care hospital stay of no more than 15 days....

Group Health officials based their interpretation of the temporary absence guidelines on an example provided in OPL-54 that is reprinted on Page 2 of their response. The example is in conflict with other parts of OPL-54 as well as the regional guidance quoted above.

Group Health's complete response is included with this report as Appendix B.

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Final determinations as to the actions taken on all matters reported will be made by the U.S. Department of Health and Human Services action official named below. We request that you respond to the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of the Inspector General, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to

made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at <http://oig.hhs.gov/>

To facilitate identification, please refer to Common Identification Number A-05-0 1-00070 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Paul Swanson". The signature is written in a cursive, flowing style.

Paul Swanson
Regional Inspector General.
for Audit Services

Direct Reply to HHS Action Official:
Director, Office of Managed Care
33-02-o 1
7500 Security Boulevard
Baltimore, Maryland 2 1244- 1850

GROUP HEALTH PLAN - MISSOURI

VARIABLE APPRAISAL OF STATISTICAL SAMPLE

Universe:	890
Sample Size:	100
Nonzero Items:	13
Value of Sample:	\$11,089

Mean:	110.89
Standard Deviation:	479.57
Standard Error:	45.18
Skewness:	7.48
Kurtosis:	65.40
Point Estimate:	\$98,689

Projection at the 90 Percent Confidence Level:

Lower Limit:	\$31,921
Upper Limit:	\$165,457
Precision Amount:	\$66,768
Precision Percent:	67.65%

October 19, 2001

Mr. David Shaner
Department of Health and Human Services
Office of the Inspector General
Office of Audit Services
277 West Nationwide Boulevard, Suite 225
Columbus, OH 43215

RE: CIN A-05-01-00070 "Review of Medicare Payments for Beneficiaries with Institutional Status for Group Health Plan, Inc."

Dear Mr. Shaner:

Thank you for allowing Group Health Plan, Inc. ("GHP") the opportunity to respond to (CIN-A05-01-00070) (the "Draft Report") dated August 21, 2001 and issued by the Office of Inspector General for the Department of Health and Human Services ("OIG"). This report is a result of your review of Medicare payments for beneficiaries reported as institutionalized by GHP between January 1, 1998 and December 31, 1999.

As per our telephone conversations of September 26, 2001, and e-mail of October 16, 2001, you granted GHP's request for an extension until October 19, 2001 to respond to the Draft Report. The appropriate management staff of GHP has reviewed the Draft Report and offers the following comments in response to the review and resulting recommendations.

I. RESULTS OF THE OIG AUDIT

The OIG sampled 100 beneficiaries records from a universe provided by the Centers for Medicare and Medicaid Services ("CMS"). From that sample, the OIG reported the following:

- "Group Health received Medicare overpayments totaling \$11, 089 for 13 beneficiaries incorrectly classified as institutionalized during the period January 1, 1998 through December 31, 1999. Based on our sample results we estimate that Group Health Medicare overpayments of \$98, 689 for beneficiaries incorrectly classified as institutionalized."
- "In addition, we questioned payments for three beneficiaries because they were hospitalized during the first month that they were claimed at the higher institutional payment rate. Enhanced rates cannot be claimed for the first 30-day period of institutional residency if the beneficiary has a hospital stay during that period. After the initial month of institutional residency hospital stays of 15 days or less do not void a beneficiary's institutional status. Payment at the higher rate continues if the beneficiary enters the hospital from the nursing facility and returns to the nursing facility following the hospital stay."

II. OIG RECOMMENDATIONS AND GHP RESPONSES

A. Recommendation Number 1: GHP Refund Specific Overpayments Totaling \$11,089

The OIG recommended that GHP refund specific overpayments identified by OIG's review totaling \$11,089. GHP has reviewed the thirteen reported overpayments and does not concur with the OIG findings regarding three specific cases of members hospitalized during the first month of the audit period. GHP submitted those cases based on its interpretation of OPL 54, attached. The initial example in OPL 54 under "Temporary Absence" provides in relevant part:

Temporary absences. HCFA will continue to pay the institutionalized AAPCC payment rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave if a bed is being held and paid for on behalf of the member. Temporary interruptions (less than 15 days) for medical necessity will be counted toward the 30-day requirement. In order to clarify the residency requirement, the use of the term "calendar month" cannot be used. A calendar month can have 28 to 31 days and thus cannot be substituted for 30 days.

The following examples are being proved to clarify these residency requirements:

1. A member of a risk contracting organization enters an institution identified above on March 2. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residence requirements. The HMO/CMP will be paid the institutional rate for the month of April.

OPL #54 states that CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization if a bed is being held and paid for on behalf of the member. Temporary interruptions (less than 15 days) for medical necessity will be counted toward the 30-day requirement. GHP has reviewed the thirteen cases the OIG identified as overpayments and contends that the following three cases were incorrectly identified, as they met the standards set forth in the OPL 54 and, as such, the higher institutional rate paid by Medicare was appropriate:

1. Medicare ID # XXXXXXXXXXXX –This member was admitted to XXXXX Skilled Nursing Facility on March 19, 1999. GHP records indicate the member was discharged from XXXXX (the skilled facility) and admitted as an inpatient to XXXXX Hospital from April 10, 1999 through April 15, 1999. On April 15, 1999, the member was readmitted to XXXXX (the skilled facility). Prior to submitting this member's name to CMS for the higher institutional payment, GHP obtained verbal confirmation from XXXXX (the skilled facility) that the member had met the thirty-day requirement under OPL 54. As the member was an institutional resident on April 2, 1999 through April 30, 1999, the five-day interruption for medical necessity would be counted toward the thirty-day requirement. Therefore, GHP should qualify for the May 1999 institutionalized payment rate.
2. Member ID # XXXXXXXXXXXX-This member was admitted to XXXXX (a nursing facility) on July 15, 1999. GHP records indicate the member was discharged from XXXXX (the nursing facility) and admitted inpatient to XXXXX Hospital from August 4, 1999 through August 6, 1999. On August 6, 1999, the member was readmitted to XXXXX (the nursing facility). Prior to submitting this member's name to CMS for the higher institutional payment, GHP obtained verbal confirmation from XXXXX (the nursing facility) that the member had met the thirty-day requirement under OPL 54. As the member was an institutional resident on August 2, 1999 through August 30, 1999, the two-day

interruption for medical necessity would be counted toward the thirty-day requirement. Therefore, GHP should qualify for the September 1999 institutionalized payment rate.

3. Member ID # XXXXXXXXXXXX- Member was admitted to XXXXX Nursing Facility on September 10, 1998. GHP records indicate the member was discharged from XXXXX (the nursing facility) and admitted inpatient to XXXXX Hospital from October 13, 1998 through October 15, 1998. On October 15, 1998, the member was readmitted to XXXXX (the nursing facility). Prior to submitting this member's name to CMS for the higher institutional payment, GHP obtained verbal confirmation from XXXXX (the nursing facility) that the member had met the thirty-day requirement under OPL 54. As the member was an institutional resident on October 2, 1998 through October 31, 1998, the two-day interruption for medical necessity would be counted toward the thirty-day requirement. Therefore, GHP should qualify for the November 1998 institutionalized payment rate.

GHP's policies and procedures regarding confirming institutional status during 1998 and 1999 reflected the following:

- Verifying if the member was institutionalized at the time of enrollment with GHP;
- Adding the confirmed member to an internal GHP log; and
- Contacting the nursing home via telephone on a monthly basis to determine the status of the member, which included:
 1. If the thirty-day requirement for institutionalized status had been met;
 2. If the member was discharged since the last telephone contact with the nursing home for any reason; and
 3. If the member was deceased, changed nursing homes or physicians, or if the member disenrolled from GHP.

Based upon the above information, GHP believes the OIG's determination of the overpayment amount of the sample should be decreased. After this adjustment is made, GHP will refund to CMS the applicable amount.

B. Recommendation Number 2: GHP Review the Balance of the Institutionalized Beneficiary Universe to Identify Additional Overpayments Estimated at \$98,689

The OIG further recommended that GHP review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. The OIG estimated total overpayments to be \$98,689. Based on the three cases identified in Section II.A above, GHP challenges a portion of the sample used to determine the error rate and therefore believes that the \$98,686 estimate may be incorrect. The estimated rate of error that is reported by the OIG for the entire institutionalized beneficiary universe should be adjusted down, given that three of the original thirteen alleged errors appears to be inappropriately designated as overpayments. GHP will work with CMS to appropriately address any concerns regarding the balance of the universe of institutionalized beneficiaries for the audit time period.

III. INTERNAL CONTROLS

The OIG has stated the following:

“Group Health's current internal control procedures for verifying the institutional residency of the Medicare beneficiaries enrolled in the MCO are adequate.”

Mr. David Shaner
October 19, 2001
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“We are making no recommendations related to the MCO’S internal controls because after our audit period, Group Health implemented new verification procedures for institutional residency.”

GHP initiated changes in its verification and notification process prior to the November 2000 audit review period, and in February 2001 initiated an enhanced tracking process for institutionalized beneficiaries. GHP will continue to review its policies and procedures relating to institutional residency in order to prevent submission for payment of a nonverified case.

On behalf of GHP, I would like to thank the OIG for the additional 35 days to respond to the Draft Report. If you should have any questions regarding the above, please contact me by e-mail at geclark@ghp.com or by telephone (314) 506-1808.

Sincerely,

Geneva Clark
Director of Compliance
GROUP HEALTH PLAN, INC.